

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0044891</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Alden Alma Nelson Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>550 S. Mulford</u> <u>Rockford</u> <u>61108</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Winnebago</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>STEVEN M. KROLL</u> (Title) <u>Chief Financial Officer</u>	
<b>Telephone Number:</b> <u>(815) 484-1002</u> <b>Fax #</b> <u>(773) 286-3746</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> <b>Fax #</b> ( )	
<b>IDPA ID Number:</b> <u>36-4367437</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>08/01/2000</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>STEVEN M. KROLL</u> <b>Telephone Number:</b> <u>(773) 286-3883</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Alma Nelson Manor# 0044891 Report Period Beginning: 01/01/2003 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>268</u>	Skilled (SNF)	<u>268</u>	<u>97,820</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>268</u>	TOTALS	<u>268</u>	<u>97,820</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,984</u>	<u>4,502</u>	<u>21,738</u>	<u>41,224</u>	8
9	SNF/PED					9
10	ICF	<u>29,088</u>	<u>4,157</u>	<u>220</u>	<u>33,465</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,072</u>	<u>8,659</u>	<u>21,958</u>	<u>74,689</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 76.35%

D. How many bed-hold days during this year were paid by Public Aid?

none (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/01/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/01/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 120 and days of care provided 21,465Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2003

Ending: 12/31/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	425,118	46,215	6,600	477,933	1,950	479,883		479,883			1
2	Food Purchase		417,865		417,865	(35,563)	382,302	23,211	405,513			2
3	Housekeeping	317,493	50,414		367,907	713	368,620		368,620			3
4	Laundry	82,139	34,184		116,323	423	116,746		116,746			4
5	Heat and Other Utilities			227,486	227,486		227,486	(129)	227,357			5
6	Maintenance	91,414	1,327	138,681	231,422	739	232,161	15,574	247,735			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	916,164	550,005	372,767	1,838,936	(31,738)	1,807,198	38,656	1,845,854			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			35,000	35,000		35,000		35,000			9
10	Nursing and Medical Records	4,002,766	324,125	12,627	4,339,518	12,038	4,351,556	(108,881)	4,242,675			10
10a	Therapy	247,951			247,951		247,951		247,951			10a
11	Activities	94,729	1,027	4,812	100,568	144	100,712	(1,519)	99,193			11
12	Social Services	70,285			70,285		70,285		70,285			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	4,415,731	325,152	52,439	4,793,322	12,182	4,805,504	(110,400)	4,695,104			16
	<b>C. General Administration</b>											
17	Administrative	220,188			220,188		220,188		220,188			17
18	Directors Fees											18
19	Professional Services			1,002,287	1,002,287		1,002,287	(960,534)	41,753			19
20	Dues, Fees, Subscriptions & Promotions			54,679	54,679		54,679	(42,854)	11,825			20
21	Clerical & General Office Expenses	644,310	29,693	221,794	895,797	687	896,484	50,322	946,806			21
22	Employee Benefits & Payroll Taxes			818,163	818,163	19,608	837,771	84,957	922,728			22
23	Inservice Training & Education											23
24	Travel and Seminar			31,872	31,872		31,872	15,560	47,432			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			183,540	183,540		183,540	10,824	194,364			26
27	Other (specify):*			84,530	84,530		84,530	(84,530)				27
28	<b>TOTAL General Administration</b>	864,498	29,693	2,396,865	3,291,056	20,295	3,311,351	(926,256)	2,385,095			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,196,393	904,850	2,822,071	9,923,314	739	9,924,053	(997,999)	8,926,054			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number Alden Alma Nelson Manor

#0044891

Report Period Beginning: 01/01/2003 Ending: 12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			39,285	39,285	(739)	38,546	342,164	380,710			30
31	Amortization of Pre-Op. & Org.							2,447	2,447			31
32	Interest			97,328	97,328		97,328	375,324	472,652			32
33	Real Estate Taxes							188,441	188,441			33
34	Rent-Facility & Grounds			568,574	568,574		568,574	(564,319)	4,255			34
35	Rent-Equipment & Vehicles			21,519	21,519		21,519	28,680	50,199			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			726,706	726,706	(739)	725,967	372,737	1,098,704			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,052,979	1,636,146	2,689,125		2,689,125	(367,909)	2,321,216			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,730	146,730		146,730		146,730			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,052,979	1,782,876	2,835,855		2,835,855	(367,909)	2,467,946			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,196,393	1,957,829	5,331,653	13,485,875		13,485,875	(993,171)	12,492,704			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2003

Ending:

12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (1,519)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(225)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,158)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,669)	21		17
18	Fines and Penalties	(28,810)	32		18
19	Entertainment	(125)	20		19
20	Contributions	(4,213)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,018)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,530)	27		24
25	Fund Raising, Advertising and Promotional	(35,639)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,906)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(657,104)	Various	34
35	Other- Attach Schedule	(166,161)	pg5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (823,265)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (993,171)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Alma Nelson Manor

ID# 0044891

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fee on utilities	\$ (4,765)	5	1
2				2
3	Other Income (flu shots)	(297)	10	3
4	Interest on resident acct. (4977)	(2,179)	32	4
5	Vendor Settlements (4983)	(328)	21	5
6	Back out 30.13% of IHCA dues	(3,579)	20	6
7	Record additional Def maint exp to correct amt	738	6	7
8	Alma LLC - Int to Related Party - AMS	(41,680)	32	8
9	Alma LLC - Int to Related Party - Rockford Inv.	(18,800)	32	9
10	Adj depreciation to correct amt on detail	337	30	10
11	Marketing Manager	(50,986)	21	11
12	Backout prior yr vend. Settlement costs (bed tax)	(29,204)	21	12
13	RC f21 t6 - misc vend sett.	(237)	6	13
14	RC f21 t6 - misc vend sett.	237	21	14
15	Backout prior yr vend. Settlement costs (maint.)	237	6	15
16	Backout Refin Fee.	(8,000)	19	16
17	Marketing Employ.Benefits Deduction	(7,656)	22	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(166,161)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2003

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,158)	0	0	28,369	0	0	0	0	0	0	0	23,211	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,765)	0	4,636	0	0	0	0	0	0	0	0	(129)	5
6	Maintenance	738	0	15,054	0	0	0	(71)	(147)	0	0	0	15,574	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(9,185)</b>	<b>0</b>	<b>19,690</b>	<b>28,369</b>	<b>0</b>	<b>0</b>	<b>(71)</b>	<b>(147)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>38,656</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(297)	0	0	(107,139)	(1,445)	0	0	0	0	0	0	(108,881)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,519)	0	0	0	0	0	0	0	0	0	0	(1,519)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,816)</b>	<b>0</b>	<b>0</b>	<b>(107,139)</b>	<b>(1,445)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(110,400)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,018)	0	(949,516)	0	0	0	0	0	0	0	0	(960,534)	19
20	Fees, Subscriptions & Promotions	(43,556)	0	702	0	0	0	0	0	0	0	0	(42,854)	20
21	Clerical & General Office Expenses	(86,949)	27,405	41,327	41,818	26,721	0	0	0	0	0	0	50,322	21
22	Employee Benefits & Payroll Taxes	(7,656)	0	86,523	0	6,090	0	0	0	0	0	0	84,957	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15,560	0	0	0	0	0	0	0	0	15,560	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,463	361	0	0	0	0	0	0	0	0	10,824	26
27	Other (specify):*	(84,530)	0	0	0	0	0	0	0	0	0	0	(84,530)	27
28	<b>TOTAL General Administration</b>	<b>(233,710)</b>	<b>37,868</b>	<b>(805,043)</b>	<b>41,818</b>	<b>32,811</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(926,256)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(244,710)</b>	<b>37,868</b>	<b>(785,353)</b>	<b>(36,952)</b>	<b>31,366</b>	<b>0</b>	<b>(71)</b>	<b>(147)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(997,999)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2003

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	337	329,422	10,584	0	1,821	0	0	0	0	0	0	342,164 30
31	Amortization of Pre-Op. & Org.	0	0	2,092	0	0	355	0	0	0	0	0	2,447 31
32	Interest	(91,694)	402,188	61,842	0	2,450	538	0	0	0	0	0	375,324 32
33	Real Estate Taxes	0	178,730	8,692	0	1,019	0	0	0	0	0	0	188,441 33
34	Rent-Facility & Grounds	0	(579,243)	14,924	0	0	0	0	0	0	0	0	(564,319) 34
35	Rent-Equipment & Vehicles	0	0	28,680	0	0	0	0	0	0	0	0	28,680 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(91,357)</b>	<b>331,097</b>	<b>126,814</b>	<b>0</b>	<b>5,290</b>	<b>893</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>372,737 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(88,850)	(114,822)	(164,237)	0	0	0	0	0	(367,909) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(88,850)</b>	<b>(114,822)</b>	<b>(164,237)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(367,909) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(336,067)</b>	<b>368,965</b>	<b>(658,539)</b>	<b>(125,802)</b>	<b>(78,166)</b>	<b>(163,344)</b>	<b>(71)</b>	<b>(147)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(993,171) 45</b>



Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2003

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See pg. 6L						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 rental income	\$ 579,243	Alma Nelson Manor, LLC	0.00%	\$	\$(579,243)	1
2	V	21 miscell. G&A		Alma Nelson Manor, LLC		27,405	27,405	2
3	V	33 real estate taxes		Alma Nelson Manor, LLC		178,730	178,730	3
4	V	26 insurance		Alma Nelson Manor, LLC		10,463	10,463	4
5	V	32 interest on mortgage		Alma Nelson Manor, LLC		341,708	341,708	5
6	V	32 interest on other loans		Alma Nelson Manor, LLC		60,480	60,480	6
7	V	30 depreciation		Alma Nelson Manor, LLC		329,422	329,422	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 579,243			\$ 948,208	\$ * 368,965	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2003 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 employee benefits	\$	Alden Management Services		\$ 86,523	\$ 86,523
16	V	19 profess. Fees	970,090	Alden Management Services		20,574	(949,516)
17	V	21 g & a		Alden Management Services		41,327	41,327
18	V	5 utilities		Alden Management Services		4,636	4,636
19	V	6 maintenance		Alden Management Services		15,054	15,054
20	V	24 auto/travel		Alden Management Services		15,560	15,560
21	V	26 Insurance		Alden Management Services		361	361
22	V	20 subscriptions/etc		Alden Management Services		702	702
23	V	30 depreciation		Alden Management Services		10,584	10,584
24	V	31 amortization		Alden Management Services		2,092	2,092
25	V	33 real estate tax		Alden Management Services		8,692	8,692
26	V	34 rent		Alden Management Services		14,924	14,924
27	V	35 rent-equip/vehicles		Alden Management Services		28,680	28,680
28	V	32 interest		Alden Management Services		61,842	61,842
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 970,090			\$ 311,551	\$ * (658,539)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube-feeding	\$ 13,476	Pyramid Health Care	100.00%	\$ 41,845	\$ 28,369	15
16	V	10 nursing supplies	118,806	Pyramid Health Care		11,667	(107,139)	16
17	V	39 perdiems/other supplies	193,152	Pyramid Health Care		104,302	(88,850)	17
18	V	21 gen'l & admin		Pyramid Health Care		41,818	41,818	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 325,434			\$ 199,632	\$ * (125,802)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 drugs	\$ 414,732	Forum Extended Care II	100.00%	\$ 350,370	\$ (64,362)	15
16	V	10 house stock	9,311	Forum Extended Care II		7,866	(1,445)	16
17	V	39 I. V.	325,146	Forum Extended Care II		274,686	(50,460)	17
18	V	22 employee benefits		Forum Extended Care II		6,090	6,090	18
19	V	21 gen'l & admin		Forum Extended Care II		26,721	26,721	19
20	V	32 interest		Forum Extended Care II		2,450	2,450	20
21	V	33 real estate tax		Forum Extended Care II		1,019	1,019	21
22	V	30 depreciation		Forum Extended Care II		1,821	1,821	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 749,189			\$ 671,023	\$ * (78,166)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 therapy	\$ 1,574,166	Community Physical Therapy	100.00%	\$ 1,409,929	\$ (164,237)	15
16	V	32 interest		Community Physical Therapy		538	538	16
17	V	31 amortization		Community Physical Therapy		355	355	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,574,166			\$ 1,410,822	\$ * (163,344)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Alma Nelson Manor# 0044891Report Period Beginning: 01/01/2003 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 repairs and maintenance	\$ 22,248	Alden Bennett Construction		\$ 22,177	\$ (71)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 22,248			\$ 22,177	\$ * (71)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2003 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 CARPET CLEANING	\$ 515	ALDEN REALTY - CARPET CARE		\$ 479	\$ (36)	15
16	V	6 FLOOR CLEANING	1,960	ALDEN REALTY - FLOOR CARE		1,849	(111)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,475			\$ 2,328	\$ * (147)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 6K

Facility Name &amp; ID Number ALDEN NURSING CENTER - ALMA NELSON

# 42010

Report Period Beginning 01/01/03

Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Waterford	Aurora
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park of Barrington	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living
Governors Park		



## STATE OF ILLINOIS

Page 6L

Facility Name &amp; ID Number ALDEN NURSING CENTER - ALMA NELSON

# 32730

Report Period Beginning 01/01/03

Ending: 12/31/03

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Nursing Home Owners	
Name	% Ownership
Note: ANC = Alden Nursing Center	
Alden Rockford Investments, LLC	100%

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Alma Nelson Manor # 0044891 Report Period Beginning: 01/01/2003 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO		322,456	2.78	6.95	SALARY	\$ 24,096	17-1	1
2	Ami Pissetsky	Finance Coordinator	Banking	1.50	182,715	2.78	6.95	SALARY	13,654	17-1	2
3	Bob Molitor	C.O.O.	Operations	1.50	203,017	2.78	6.95	SALARY	15,171	17-1	3
4	Lauren Magnusson b.	Nurse coordinator	Nursing admin		81,011	2.78	6.95	SALARY	6,054	10-1	4
5	Terry Magnusson c.	Maint. Supervisor	construt/maint		78,340	2.78	6.95	SALARY	5,854	6-1	5
6	Steven Kroll	C.F.O.	Finance	1.50	207,479	2.78	6.95	SALARY	15,504	17-1	6
7	Joan Carl	Secretary	Vice-President		212,865	2.78	6.95	SALARY	5,270	17-1	7
8											8
9	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										9
10	b. Lauren is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator										10
11	c. Terry is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										11
12											12
13								TOTAL	\$ 85,602		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Alma Nelson Manor# 0044891

Report Period Beginning:

01/01/2003Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Servcies, IncStreet Address 4200 W. Peterson Ave.City / State / Zip Code Chicago, IL 606046Phone Number ( 773) 286-3883Fax Number ( 773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">see pg 8A (also on pg 6A)</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	National City Bank		X	Mortgage	Interest Only	8/1/00	\$ 8,120,000	\$ 8,120,000		Various	\$ 341,708	1							
2												2							
3												3							
4												4							
5	National City Bank		X	Line of Credit	Interest Only	8/1/00		1,411,117		Various	68,518	5							
	Working Capital																		
6	Related Party - AMS	X		Working Capital							61,842	6							
7	Related Party - FECII	X		Working Capital							2,450	7							
8	Realted Party - CPT	X		Working Capital							538	8							
9	TOTAL Facility Related							\$ 8,120,000	\$ 9,531,117			\$ 475,056	9						
	B. Non-Facility Related*																		
10	Offset Int. exp w/ int inc.										(2,179)	10							
11	Interest Income on Corp										(225)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$				\$ (2,404)	14						
15	TOTALS (line 9+line14)							\$ 8,120,000	\$ 9,531,117			\$ 472,652	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891 Report Period Beginning: 01/01/2003 Ending: 12/31/03

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	182,242	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	178,699	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,543)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	182,273	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	178,730	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1998	8			
	1999	9			
	2000	171,256	10		
	2001	174,354	11		
	2002	178,699	12		
Accrual based on 2% increase over prior year bill.					
			13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden Alma Nelson Manor COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0044891

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-27-152-003</u>	<u>Nursing home facility</u>	\$ <u>6,145.70</u>	\$ <u>6,145.70</u>
2. <u>12-27-152-002</u>	<u>Nursing home facility</u>	\$ <u>86,509.64</u>	\$ <u>86,509.64</u>
3. <u>12-27-152-001</u>	<u>Nursing home facility</u>	\$ <u>86,044.06</u>	\$ <u>86,044.06</u>
4. _____	<u>Related Party - Alden Management</u>	\$ <u>125,008.00</u>	\$ <u>8,692.00</u>
5. _____	<u>Related Party - Forum</u>	\$ <u>8,317.00</u>	\$ <u>1,019.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>312,024.40</u>	\$ <u>188,410.40</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 60,952

B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home			\$ 700,000	1
2					2
3	TOTALS			\$ 700,000	3

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2003 Ending: 12/31/03

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6	268				7,000,000	222,222	31.5	222,222		759,259	6
7	Related party-Forum			1978	15,909		22			15,909	7
8											8
	<b>Improvement Type**</b>										
9		GT Mechanical - replace 75 ton compressor		2000	23,550	2,355	10	2,355		7,850	9
10		Alden Bennett Const.		2001	16,737	1,674	10	1,674		4,882	10
11		Pro com systems		2001	4,055	406	10	406		1,183	11
12		Alden Bennett Const.		2001	2,098	210	10	210		577	12
13		New Horz. Comm		2001	1,701	170	10	170		454	13
14		Alden Bennett Const.		2001	1,816	182	10	182		484	14
15		Alden Bennett Const.		2001	2,263	226	10	226		585	15
16		Alden Bennett Const.		2001	2,828	283	10	283		707	16
17		Seams -rebuild engine		2001	4,938	494	10	494		1,193	17
18		Alden Bennett Const.		2001	1,632	163	10	163		394	18
19		CSI Coker - belt/heating element		2001	5,256	526	10	526		1,139	19
20		Alden Bennett Const.		2001	3,198	320	10	320		693	20
21		GT Mechanical - heater		2001	2,406	241	10	241		501	21
22		GT Mechanical, Inc. - Repair Air Conditioner		2002	11,519	1,152	10	1,152		1,728	22
23		Pro Com Systems - Repair Nurse Call System		2002	1,862	186	10	186		310	23
24		GT Mechanical, Inc. - Repair Heater		2002	1,996	200	10	200		383	24
25		FE Moran - Repair - Fire Alarm System		2002	1,825	183	10	183		259	25
26		Nelson Carlson - Repair Water Main		2002	2,407	241	10	241		461	26
27		ABC - Light Fixtures		2003	2,283	457	5	457		457	27
28		GT Mech - Replace Pump		2003	1,532	102	10	102		102	28
29		Simplex - Repair Smoke Detector system		2003	4,238	283	10	283		283	29
30		ABC - Roof Repair		2003	3,953	176	15	176		176	30
31		CSI Coker - Repair Dishwasher		2003	3,291	196	7	196		196	31
32		ABC - Repair C wing main A/C power		2003	2,177	91	10	91		91	32
33		ABC - Repair Boiler		2003	23,646	131	15	131		131	33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 Building Improvements		\$	\$		\$	\$	\$		37
38 Alden Design - HVAC	2000	5,142	257	20	257		836		38
39 Alden Design - elect. /plumbing	2000	3,089	154	20	154		502		39
40 Alden Design - misc	2001	22,472	1,124	20	1,124		3,371		40
41 Alden Design - misc	2001	22,412	1,121	20	1,121		3,362		41
42 ABC - laundry room repairs	2001	94,243	4,712	20	4,712		13,744		42
43 ABC - laundry room repairs	2001	11,608	580	20	580		1,499		43
44 ABC - laundry room repairs	2001	9,602		20			40		44
45 ABC - laundry room repairs	2002	(9,602)		20			(40)		45
46 ABC - Carpet	2002	1,231	82	20	82		82		46
47 ABC - Chimney	2002	3,032	152	20	152		152		47
48 Medline - Window Blinds	2003	1,706	223	7	223		223		48
49 Tyco - installation of smoke detectors	2003	6,753	450	15	450		450		49
50 Code Alert - Update system	2003	5,007	167	15	167		167		50
51 ABC - 4 doors	2003	2,449	20	10	20		20		51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)		\$ 7,328,260	\$ 241,909		\$ 241,909	\$	\$ 824,793		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,328,260	\$ 241,909		\$ 241,909		\$ 824,793	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		\$ 7,399,987	\$ 244,186		\$ 244,186		\$ 877,615	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 739,058	\$ 128,826	\$ 128,826	\$	Various	\$ 464,482	71
72	Current Year Purchases	24,084	3,522	3,522		Various	3,522	72
73	Fully Depreciated Assets	46,013	2,125	2,125		Various	46,013	73
74								74
75	TOTALS	\$ 809,156	\$ 134,472	\$ 134,472	\$		\$ 514,017	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	98-'03	\$ 11,860	\$ 2,052	\$ 2,052	\$	3	\$ 11,658	76
77										77
78										78
79										79
80	TOTALS			\$ 11,860	\$ 2,052	\$ 2,052	\$		\$ 11,658	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,921,003	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 380,710	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 380,710	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,403,290	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party- cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                      \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 19,833 Description: copy machine lease \$18,972, postage meter \$861

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>non-patient transport</u>		\$ <u>140.50</u>	\$ <u>1,686</u>	17
18	<u>Related Party - AMS</u>		<u>2,390.00</u>	<u>28,680</u>	18
19					19
20					20
21	TOTAL		\$ <u>2,530.50</u>	\$ <u>30,366</u>	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2004 \$                     

13.                      /2005 \$                     

14.                      /2006 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled nurses on site</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 483,397	\$		\$ 483,397	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			134,243			134,243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			866,758			866,758	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16A	# of prescrpts				307,807		307,807	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see pg 16A					529,011		529,011	13
14	TOTAL			\$		\$ 1,484,398	\$ 836,818		\$ 2,321,216	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2003

Ending:

12/31/03

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 330,622	\$ 330,622	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000 )	2,355,698	2,355,698	3
4	Supply Inventory (priced at )	848	848	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,853	7,853	6
7	Other Prepaid Expenses	3,168	27,697	7
8	Accounts Receivable (owners or related parties)	1,590,922	470,740	8
9	Other(specify): Due from 3rd parties	(139,816)	(139,816)	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,149,295	\$ 3,053,642	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,436,265	12
13	Land		700,000	13
14	Buildings, at Historical Cost		7,000,000	14
15	Leasehold Improvements, at Historical Cost	319,766	319,766	15
16	Equipment, at Historical Cost	147,581	683,581	16
17	Accumulated Depreciation (book methods)	(96,731)	(1,222,257)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 370,616	\$ 8,917,355	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,519,911	\$ 11,970,997	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,155,683	\$ 2,155,683	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	215,429	215,429	28
29	Short-Term Notes Payable	1,411,117	1,411,117	29
30	Accrued Salaries Payable	386,569	386,569	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,342	33,342	31
32	Accrued Real Estate Taxes(Sch.IX-B)		182,274	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Due to affiliates & other accr exps	100,800	135,479	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 4,302,940	\$ 4,519,893	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		8,463,990	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 8,463,990	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,302,940	\$ 12,983,883	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 216,971	\$ (1,012,886)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,519,911	\$ 11,970,997	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (107,995)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (107,995)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	324,966	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 324,966	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 216,971	24 *

\* This must agree with page 17, line 47.



## STATE OF ILLINOIS

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Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2003

Ending: 12/31/03

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,813,863	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,813,863	3
<b>B. Ancillary Revenue</b>			
4	Day Care	1,519	4
5	Other Care for Outpatients		5
6	Therapy	208,869	6
7	Oxygen	7,309	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 217,697	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,104	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,394	19
20	Radiology and X-Ray	1,347	20
21	Other Medical Services	24,217	21
22	Laundry	350	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 116,857	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	225	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 225	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc other income (see 19A)	4,780	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,780	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,153,423	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,838,936	31
32	Health Care	4,793,322	32
33	General Administration	3,291,056	33
<b>B. Capital Expense</b>			
34	Ownership	726,706	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,689,125	35
36	Provider Participation Fee	146,730	36
<b>D. Other Expenses (specify):</b>			
37	Related party salary allocations	(657,419)	37
38	located in col 1 (on pg 3 & 4)		38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,828,456	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	324,966	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 324,966	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2003

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12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,088	2,144	\$ 70,250	\$ 32.77	1
2	Assistant Director of Nursing	2,856	2,860	96,559	33.76	2
3	Registered Nurses	23,893	24,565	737,601	30.03	3
4	Licensed Practical Nurses	51,541	54,427	1,190,901	21.88	4
5	Nurse Aides & Orderlies	142,560	148,324	1,654,513	11.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,724	3,909	46,267	11.84	8
9	Activity Director	1,704	1,768	23,077	13.05	9
10	Activity Assistants	7,826	8,127	71,652	8.82	10
11	Social Service Workers	4,299	4,285	70,285	16.40	11
12	Dietician					12
13	Food Service Supervisor	3,268	3,380	62,638	18.53	13
14	Head Cook	2,401	2,648	33,188	12.53	14
15	Cook Helpers/Assistants	36,867	38,350	322,304	8.40	15
16	Dishwashers					16
17	Maintenance Workers	1,808	2,080	62,811	30.20	17
18	Housekeepers	34,602	36,388	307,037	8.44	18
19	Laundry	7,895	8,228	82,139	9.98	19
20	Administrator	2,024	2,080	79,656	38.30	20
21	Assistant Administrator	1,640	1,680	42,715	25.43	21
22	Other Administrative	13,273	13,897	375,354	27.01	22
23	Office Manager					23
24	Clerical	9,092	9,585	92,448	9.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,307	4,451	106,654	23.96	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	736	821	10,925	13.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	358,404	373,997	\$ 5,538,974 *	\$ 14.81	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	550/mo	\$ 6,600	1-3	35
36	Medical Director	2958/mo	35,500	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	378/mo	4,536	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,636	11-3	44
45	Social Service Consultant	16	876	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	64	\$ 50,148		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
			\$	Workers' Compensation Insurance	\$ 90,044	IDPH License Fee	\$
				Unemployment Compensation Insurance	97,174	Advertising: Employee Recruitment	1,058
Taylor,G	Administrator		79,656	FICA Taxes	416,566	Health Care Worker Background Check	742
Gregory Kelly	Asst.Administrator		42,715	Employee Health Insurance	59,559	(Indicate # of checks performed 106 )	
				Employee Meals	35,563		
				Illinois Municipal Retirement Fund (IMRF)*			
Executive / Management	Executive Mgmt		97,817	Related Party - FECII	6,090	Surety Bond Fee, Dues & Subscription	1,022
TOTAL (agree to Schedule V, line 17, col. 1)				Union Health & Welfare	76,317	II. Health Care Assoc.	8,301
(List each licensed administrator separately.)			\$ 220,188	Dental, Life, Relations, Pension & Misc	54,953		
B. Administrative - Other				Background Cks., Tuition & Drug Test	5,818	Related Party - AMS	702
				401k Match, Vaccinations, Other	1,778	Less: Public Relations Expense	(
Description			Amount	Marketing Employ.Benefits Deduction	(7,656)	Non-allowable advertising	(
			\$	Related Party - AMS	86,523	Yellow page advertising	(
				TOTAL (agree to Schedule V,	\$ 922,728	TOTAL (agree to Sch. V,	\$ 11,825
				line 22, col.8)		line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	
C. Professional Services							
Vendor/Payee	Type		Amount				
AMS	Management Fees	\$	970,090				
BDO Siedman	Accounting Fees		3,000				
Ken Fisch / Greenberg	Legal Fees		15,473				
Jennings Law / Dana Cons.	401k services		680				
David A Aaby	Legal Fees		1,043				
Cambridge Realty	Refinancing		8,000				
Medi.Com	Billing Consultants		523				
Talx	Unemployment Consulting		262				
Schlueter & Other	Collections & Misc		722				
National City	Renew Loan		2,494				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,002,287				

\* Attach copy of IMRF notifications

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	GT Mechanical - A/C	6/01	\$ 2,021	5	\$	\$ 236	\$ 404	\$ 404	\$ 404	\$ 404	\$ 169	\$ 0	\$ 0
2	GT Mechanical - Chiller	7/01	1,988	5		199	397	397	397	397	201	0	0
3	CSI Corker - dishwasher	12/01	3,404	5		57	681	681	681	681	623	0	0
4	no 2002 additions												
5	no 2003 additions												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 7,413		\$	\$ 492	\$ 1,482	\$ 1,482	\$ 1,482	\$ 1,482	\$ 993	\$	\$

Facility Name & ID Number Alden Alma Nelson Manor

STATE OF ILLINOIS

# 0044891

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Healthcare Assoc. \$11,880
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,292 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 146,730  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 35,563 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not Required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - Alma Nelson  
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Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(35,563)	Employee Meal
	22	35,563	Employee Meal
22		(15,955)	Uniforms
	10	12,038	Uniforms
	6	0	Uniforms
	4	423	Uniforms
	1	1,950	Uniforms
	3	713	Uniforms
	11	144	Uniforms
	21	687	Uniforms
19			R/E Tax Appeal
	33		R/E Tax Appeal
		<hr/> 0	Net should be 0